Georgetown University Health Policy Institute
Center for Children and Families

Coordinating Medicaid and CHIP

Summary/Framing

The Children's Health Insurance Program (CHIP) was launched in 1997 to provide coverage for low-income children and families who were ineligible for Medicaid. It allowed states to expand coverage through their existing Medicaid program, to establish a separate state program, or to adopt a combination approach. The option to establish a separate program has been important to many states, but it also can make it more difficult for families to secure and retain coverage for their children when they must navigate two child health programs–Medicaid and a separate CHIP program. Fortunately, states have many strategies at their disposal for coordinating coverage between Medicaid and separate CHIP programs that can reduce the risk of children slipping through the cracks.

Background

Medicaid Expansions

In January 2009, 12 states (including the District of Columbia) opted to use CHIP funds solely to expand their Medicaid programs.[1] In these states, it is relatively easy to operate a single, unified child health coverage program. Behind the scenes, the state will need to keep track of which children qualify for Medicaid coverage at the regular matching rate versus at the CHIP matching rate, but families need not be involved in this determination. Instead, regardless of the funding source for their coverage, families use the same application and renewal procedures and the same delivery system. This arrangement is, in general, the easiest for families to navigate and requires no cross-program coordination because there is only one program—Medicaid.

Research shows that using CHIP funds to expand Medicaid results in higher enrollment, in part because coordination is not an issue.[2] In one study, Medicaid expansions showed enrollment levels 2.7 percentage points higher than combination programs, and 3.3 percentage points higher than separate CHIP programs.[3] In another study, separate programs were associated with take-up rates eight to 10 percentage points lower than those for combined programs.[4] States with combined programs experienced an annual dropout rate of 9.6 percent, compared with 13.9 percent in states with separate programs.[5]

Separate CHIP Programs

In 39 states, CHIP funds are used to run a separate health insurance program, some in combination with a Medicaid expansion.[6] In these states, there are varied levels of coordination between CHIP and Medicaid. Some states treat the programs as entirely separate, relying on different application and renewal procedures, administrative agencies, and delivery systems. Other states have sought to more closely align and coordinate their two programs. These states, for example, might use the same application and renewal form for Medicaid and their separate CHIP program. Or, they might take steps to ensure that when children become ineligible for Medicaid due to an increase in family income that they are automatically enrolled in the separate CHIP program, and vise-versa.

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State experience clearly demonstrates that increased coordination between Medicaid and separate CHIP programs yields positive outcomes, such as:

- **Families enroll and retain coverage more easily.** In a coordinated system, families do not need to understand the eligibility rules for two programs, submit applications or renewal forms for two programs, or guess which program is the right one for their child; instead, they can submit a single application (or renewal form), which is used "behind the scenes" by the state to place a child in the appropriate program. Such coordination can reduce—or even eliminate—enrollment and service delays.

- **Children stay covered, their health protected.** Research is conclusive that stable insurance coverage is key to children's health.[7] Yet low-income families often experience changes in their income and composition that may affect their eligibility for insurance and, therefore, the stability of their coverage. A system that responds to these shifts by automatically transferring children between Medicaid and a separate CHIP program can help protect children's health.

- **States have lower costs.** A well-coordinated and aligned system also can reduce state costs and administrative hassles by reducing the need for the state to engage in duplicative activities. For example, consider a state that uses different rules in Medicaid versus CHIP when calculating a family's income (e.g., it might use a gross income test in its separate CHIP program, but apply childcare and work expense disregards to children in Medicaid). Such a state might gather information that reveals a child is ineligible for CHIP only to find that it must approach the family a second time to gather the information needed to evaluate eligibility for Medicaid. If, however, a state has aligned its income counting rules, it can readily gather information from a family only once and then use it to decide if a child should be enrolled in Medicaid or the separate CHIP program.

Legislative Authority

Federal law allows states to use CHIP matching funds to expand eligibility in their Medicaid program, to create a fully separate child health program, or to adopt a combination approach. States that opt to establish a separate CHIP program have broad flexibility under federal law to align and coordinate key elements of their programs, such as administration and oversight of the programs; application and renewal procedures; outreach campaigns; delivery systems; and quality improvement initiatives. And, federal authorities historically have required, or encouraged, states to implement coordination procedures.[8] In states with separate CHIP programs, some barriers to full coordination remain, but they are relatively minor and usually can be addressed.[9]

When establishing CHIP, federal policymakers were mindful that the new initiative built upon the Medicaid program. In response, they required states to describe how they would coordinate their new CHIP programs with existing sources of coverage, including Medicaid.[10] They were sufficiently concerned about Medicaid-eligible children being erroneously placed in CHIP, that they included a "screen and enroll" requirement in the CHIP statute. Under this requirement, states with separate CHIP programs must screen all applying children for Medicaid eligibility and, if appropriate, enroll them in Medicaid. States must also assist families in applying for CHIP if their child applies for Medicaid and is not eligible.[11] The effectiveness of these "screen

and enroll" provisions depends on the level of coordination between programs. If, for example, both programs use the same income, asset and deduction rules, workers can more easily determine eligibility for either program.

Strategies

1. In function and appearance, create "one" child health coverage system. Though a state may designate CHIP and Medicaid as separate programs, they can operate on-the-ground as part of a single, unified child health coverage system**.** In fact, program distinctions should be invisible to families. There is no reason families should be obliged to understand and navigate the differences between Medicaid and CHIP, or to figure out for which program their children will qualify. Key components of a unified child health coverage system include:

- A single program name, which can facilitate unified outreach activities and contribute to the sense that the state operates a single, unified child health coverage system.
- Issuance of identical (or similar) enrollment cards to avoid the appearance that some families can access better care.
- Use of the same income and asset counting rules, verification requirements, and renewal procedures—such as establishing 12-month continuous eligibility—for both programs.
- A single agency to determine eligibility for both programs based on a unified application process (e.g., a single application or renewal form with the same verification requirements for CHIP and Medicaid-eligible children). States that do not use the same agency or that use contractors to determine CHIP eligibility, can co-locate eligibility workers or rely on electronic means to transfer information.
- Elimination of age-based eligibility rules (sometimes called "staircase" eligibility") so that siblings can qualify for the same program.
- Access to the same service providers for children in both programs.

2. Promote smooth transitions between the two child health programs. Since low- and moderate-income families frequently experience changes in circumstances that cause them to lose eligibility for Medicaid or CHIP, it is vital to ensure that children can move seamlessly between the two programs. To promote smooth transitions, states can take action to ensure that:

- Children are automatically transferred between programs, with no interruption of coverage, if their family income or circumstances change. Each agency should be required to act on these transfers to ensure that no children are unnecessarily lost.
- Initial premiums for CHIP are collected *after* eligibility has been determined (instead of with the application) to eliminate the need for returning premiums to families whose children turn out to be eligible for Medicaid, as well as to avoid deterring families whose children turn out to be Medicaid-eligible from seeking applying for coverage in the first place.
- Grace periods for collecting premiums are provided when a child moves from Medicaid to CHIP to ensure uninterrupted coverage and access to care.

3. Coordinate the renewal process as well. While 92 percent of states with a separate CHIP program use a joint CHIP/Medicaid application, only 48 percent use a joint renewal form.[12] Efforts at coordination can and should extend to renewal procedures since *eligible* children continue to be "disenrolled" from public health insurance.

State Experiences

- **Providing truly seamless coverage in Massachusetts.** MassHealth is a single public health insurance program that provides coverage by combining federal Medicaid and CHIP funds and state resources. Enrollment and renewal procedures are the same for all children, and all children have access to the same delivery systems. It is only behind-the-scenes, in a process invisible to families, that the state determines which funding streams are used to finance a child's care. The range of covered benefits does vary based on family income and other factors. However, as long as a child remains eligible for MassHealth, movement among coverage categories (as a result of changes in family income or status) is accomplished through a consolidated eligibility system, without requiring the member to re-apply. Members receive written notice of any changes in their benefits.[13] (See MassHealth Web site.)

- **Coordinating renewals in Washington State.** In Washington, although different entities handle renewals for Medicaid and CHIP, the requirements are the same and the programs use the same pre-populated renewal form (i.e., a form that is filled out with information that the state already has on hand about the family). If a child's eligibility changes at renewal, a letter informs the family and a new identification card is automatically sent. If a child transfers from Medicaid to CHIP, premiums begin the month *after* the change. Following annual adjustment of the federal poverty level (FPL), an automated review determines if CHIP participants have become Medicaid-eligible. If so, an automatic transfer is made and the original eligibility review schedule remains.[14] (See Washington State Health and Recovery Services Administration Web site.)

- **No "Wrong Door" in Virginia.** In 2002, Virginia had low CHIP enrollment and families struggled to navigate between the separate Medicaid and CHIP programs. With the commitment of a new Governor, committed agency staff, and the support of the General Assembly, however, the state took some key steps, including: eliminating premiums, eliminating age-based differences in eligibility rules (i.e., expanding Medicaid for children ages six to 18 to 133% of the FPL); developing a joint application; and streamlining verification requirements across the programs. The state also adopted a "No Wrong Door" policy, meaning the family can go (or send their paperwork) to either their local Department of Social Services or to the CHIP central processing unit, and the child will be enrolled in the program for which he or she is eligible. The approved cases are then automatically forwarded to the appropriate office for ongoing case management. The end result of the no wrong door policy is that families can get coverage even if they erroneously applied for the "wrong" program. The impact of these and other improvements has been substantial. Between September, 2002 and December, 2007, CHIP enrollment in Virginia increased by more than 125 percent.[15] (See Virginia Department of Medicaid Assistance Services Web site.)

- **Electronic referral connects Medicaid and CHIP in Iowa.** In Iowa, children who lost Medicaid eligibility due to increased income were not being consistently referred to CHIP. Eligibility workers found the referral system cumbersome – forms had to be copied and faxed – and there were increasing complaints from families about loss of

coverage. In response, a team of Medicaid and CHIP administrators, staff and advocates developed an electronic referral process that was added to the Medicaid computer system. The Department of Human Services was also restructured so that the CHIP Administrator could oversee eligibility for both programs. The system has cut down on eligibility workers' paperwork and children missing out on referrals to CHIP. As a result, referrals have increased substantially: from 293 in August 2003 to 943 in August 2006. The state reports that the vast majority of these referrals are approved.[16] (See Iowa's hawk-i Web site.)

Resources

- Eligibility Levels in Medicaid & CHIP for Children, Pregnant Women, and Parents
- Enrollment Procedures in Medicaid & CHIP for Children
- Renewal Procedures in Medicaid & CHIP for Children

New Research Shows Simplifying Medicaid Can Reduce Children's Hospitalizations
Leighton Ku, Center On Budget And Policy Priorities, June 2007
This brief reports on new research indicates that increasing the continuity of children's Medicaid coverage reduces subsequent hospitalizations for chronic health conditions like asthma or diabetes. The research—a new study conducted by Dr. Andrew Bindman and his associates at the University of California at San Francisco—indicates that improving the continuity of Medicaid coverage through 12-month continuous eligibility can improve children's health and avert unnecessary hospitalization costs.

The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP
Benjamin D. Sommers, Health Affairs, November 2005
This report reviews the impact of program structure on children's disenrollment from Medicaid and CHIP. It finds that states with combined Medicaid/CHIP programs experience an annual dropout rate of 9.6 percent, compared with 13.9 percent in states with separate programs. Having separate programs increases the risk of drop out by 45 percent. The attached file is an abstract of the article.

The Effects of State Policy Design Features on Take-UP and Crowd-Out Rates for the State Children's Health Insurance Program
Cynthia Bansak and Steven Raphael , Journal of Policy Analysis and Management, June 2005
This report reviews whether CHIP programs that are separate from the state Medicaid program is associated have lower take-up rates. The authors found that separate programs were associated with take-up rates 8 to 10 percentage points lower than those for combined programs. The attached file is an abstract of the article. Order the publication on the publisher's Web site.

Simplifying Children's Medicaid And SCHIP
Karl Kronebusch and Brian Elbel, Health Affairs, May 2004
This report reviews whether a state using CHIP funds for a Medicaid expansion has an enrollment advantage over a state that has a combination Medicaid/CHIP program or a separate CHIP program. The authors find that states using Medicaid expansions have higher enrollment levels—an increase of 2.7 percentage points compared with combination programs and 2 percentage points compared with separate CHIP programs. These results may be due to the

advantages Medicaid affords as an administrative model including the potential for better continuity and more seamless integration of enrollment for agency staff, who are required to screen CHIP applicants for Medicaid eligibility, as well as for recipients who potentially shift between programs when family income changes. Finally, outreach efforts oriented around CHIP will automatically apply to Medicaid under a Medicaid expansion.

Enrolling Children in Public Insurance: SCHIP, Medicaid, and State Implementation
Karl Kronebusch and Brian Elbel, Journal of Health Politics, Policy and Law, January 2004
This report finds that states utilizing Medicaid expansions have higher enrollment levels—an increase of 2.7 percentage points compared to combination programs and an increase of 3.3 percentage points compared to separate CHIP programs. The advantage for the Medicaid expansion is found at all levels of income and is a little larger for those with relatively higher incomes (i.e., between 50 and 250 percent of the federal poverty level), which is the opposite of the fear that higher income recipients would feel more anti-Medicaid stigma.

Making the Link: Strategies for Coordinating Publicly Funded Health Care Coverage for Children
Cindy Mann, Donna Cohen Ross and Laura Cox, Center on Budget and Policy Priorities, February 2000
Many states have expanded CHIP coverage for children through a separate child health program, either exclusively or in combination with a Medicaid expansion. Each of these states, as well as those that create separate child health programs, needs to devise strategies for coordinating the new coverage program with Medicaid. This report discusses some administrative strategies, including one program name and enrollment simplifications, which could promote coordination.

Endnotes

[1] D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009).
[2] K. Kronebusch and B. Elbel, "Simplifying Children's Medicaid and SCHIP," *Health Affairs*, 23: 233-246 (May/June 2004); and B. Sommers, "The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP," *Health Affairs*, 24: 1611-1618 (November/December 2005).
[3] K. Kronebusch and B. Elbel, "Enrolling Children in Public Insurance: SCHIP, Medicaid, and State Implementation," *Journal of Health Politics, Policy, and Law*, 29: 451-489 (2004).
[4] C. Bansak and S. Raphael, "The Effects of State Policy Design Features on Take-UP and Crowd-Out Rates for the State Children's Health Insurance Program," *Journal of Policy Analysis and Management*, 26: 1449-175 (June 2005).
[5] B. Sommers, "The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP," *Health Affairs*, 24: 1611-1618 (November/December 2005).
[6] *op. cit.* (1).

[7] L. Summer and C. Mann, "Instability of Public Health Insurance Coverage For Children And Their Families: Causes, Consequences, and Remedies," Georgetown University Health Policy Institute (June, 2006); and L. Ku, "New Research Shows Simplifying Medicaid Can Reduce Children's Hospitalizations," Center On Budget And Policy Priorities (June, 2007).

[8] Centers for Medicare and Medicaid Services, "Continuing the Progress: Enrolling and Retaining Families and Children in Health Care Coverage," (August 2001).
[9] For example, in its August 17th, 2007 guidance to states, the Centers for Medicare and Medicaid Services required states seeking to cover children at 250 percent of the federal poverty level through SCHIP to use a gross income test when evaluating eligibility. As a result, such a state cannot fully align its SCHIP income counting rules with Medicaid, which, under federal law, relies on a net income test.
[10] 42 CFR 457.80
[11] 42 CFR 457.350
[12] *op. cit.* (1).
[13] FY 2006 Massachusetts Annual SCHIP Report; Personal communication with Robin Callahan, Director of Member Policy and Program Development, Massachusetts Office of Medicaid, 2007.
[14] FY 2006 Washington Annual SCHIP Report; Personal communication with Kevin Cornell, Regional Medicaid Eligibility Representative, Washington DSHS/HRSA, 2007.
[15] Personal communication with Rebecca Mendoza, Virginia Department of Medical Assistance Services, 2007.
[16] Southern Institute on Children and Families, "Covering Kids And Families: Promising Practices From The Nation's Single Largest Effort To Insure Eligible Children And Adults Through Public Health Coverage," (April 2007); and Personal communication with Mike Baldwin, Iowa Department of Human Services, 2007.

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